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Patient Information

Last Name: ____________________ First Name: ____________________ Middle Initial:______

Address: _______________________ City: ___________________ State: ______ Zip:________

Home Phone: (____)___________________ Cell Phone (____)_________________________

Employer: ____________________________ Work Phone (____)_________________________

Social Security #: ______________________ Date of Birth: ____________ ☐ Male ☐ Female

Family Physician: _____________________ Referring Physician:_________________________

Emergency Contact

Name: _______________________________ Relationship to Patient:_______________________

Home Phone: (____)___________________ Work Phone: (____)_________________________

Primary Insurance

☐ Same as the patient information – patient is the Primary insurance subscriber

Subscriber Name: ___________________________ Subscriber Date of Birth:_______________

Subscriber Employer: ________________________ Subscriber Gender: ☐ Male ☐ Female

Secondary Insurance

☐ Same as the patient information – patient is the Secondary insurance subscriber

Subscriber Name: ___________________________ Subscriber Date of Birth:_______________

Subscriber Employer: ________________________ Subscriber Gender: ☐ Male ☐ Female

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Southwest Cardiology, Inc. to render needed treatment to the above named patient.
2. I authorize Southwest Cardiology Inc to release any Information required for payment of claims.
3. I authorize payment of medical benefits to Southwest Cardiology Inc for services rendered.
4. I understand that I AM RESPONSIBLE for all charges incurred through Southwest Cardiology, Inc. Payment is expected at the time of my visit. If this cannot be done, I agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

Signature: ____ Date: ______________